Flex physical therapy and sports medicine

Update 12/2018

Patient Insurance Benefits Summary

***Please contact your insurance company and ask for your Physical Therapy benefits in an office setting. We bill as an office.**

***This needs to be complete by your first appointment! Thank you!**

Insurance Company**:** _____ Dates of coverage**:** _____ to _____

1. Do you have co-pay? YES or NO

   If yes, how much is it? $ _____ (skip to question 4)

   If no, how much is your deductible? $ _____
   How much has been met to date this year? $ _____ (continue to question 2)

2. What is your out-of-pocket maximum? $ _____ How much has been met this year? $ _____

3. What is your co-insurance percentage? _____/_____

4. Do you have a visit limit for physical therapy? YES or NO
   - Soft or Hard Limit?

5. If yes, how many visits? _____ How many have you used this year? _____

6. Is authorization for Physical Therapy required? YES or NO

7. If you are not the primary policy holder, fill out information below:

   Name: _____
   Date of Birth: _____
   Relationship to patient: _____

Benefits quoted are not a guarantee of benefits. Benefits will be determined by your insurance company once a claim has been received and processed. I understand I am responsible for any balance due after insurance is processed.

I have read and understand the above benefits.

_____	_____	_____
Printed Name	**Signature (parent/guardian must sign)**	**Date**

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